ALASKA WIC
Good Nutrition For Women, Infants & Children

Child Application

_____ ☐Boy or ☐Girl _____ _____
Last Name **First Name** **Middle Initial** **Birth Date** **Today's Date**

Your Name: _____ **Relationship to Child:** _____

Child's Social Security Number _____ **Is this child Hispanic or Latino?** ☐**No** ☐**Yes**

Select at least one of the following: ☐American Indian/Alaska Native ☐Asian ☐ White
☐ Black/African American ☐Native Hawaiian/Pacific Islander

Please answer if your child is under 2

My child's birth weight was less than 5 lbs. 9 oz	☐No	☐Yes **141**
My child was born at 37 weeks or less	☐No	☐Yes **142**
My child's immunizations are up to date	☐No	☐Yes

WIC helps families with healthy food and nutrition choices.
What concerns, if any, do you have about your child's eating behaviors or growth?
_____
_____

1. Please, tell us if your child sees a doctor, dietitian or health care provider for medical or emotional reasons, ex: hypertension, pre-hypertension, diabetes, fetal alcohol syndrome, gastrointestinal disorders or anemia. **151, 201, 341-357, 359, 360, 362, 382**
   Describe: _____
   _____
2. If your child was in the hospital in the last 3 months, please, tell us why. **359**
   _____
   _____
3. Has your child been screened or referred for lead poisoning? ☐No ☐Yes **211**
4. When was your child's last dental check-up?
   Date _____ **381**
5. Does your child have any problems eating any type of food for any reason such as dental problems, food intolerances or others? ☐No ☐Yes **354, 355, 381**
   Describe: _____
   _____
6. List any food allergies your child may have. **353**
   _____
   _____
7. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home ☐No ☐Yes **904**
8. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?
   ☐No ☐Yes **801**
9. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?
   ☐No ☐Yes **801**
10. Did a family member have a seasonal farming job with a temporary home in the last 24 months?
    ☐No ☐Yes **802**
11. What concerns, if any, do you have about anyone hurting your child? _____
    _____ **901**
12. Do you have problems taking care of your child?
    ☐No ☐Yes **902**
13. Has your child been in foster care or moved to a new foster care home within the last 6 months?
    ☐No ☐Yes **903**
14. Circle the type of milk you would like on your WIC checks or in your food box:
    Fresh **Fluid (UHT)** **Evaporated**
    Soy **Lactose Reduced** **355** **Dry**
15. What concerns, if any, do you have about having enough food to feed your family?
    Comment: _____
    _____

To Be Completed by Health Care Provider (HCP)

Medical date_____ Current Wt _____ (103, 113, 134, 135) Ht _____ (121) Hgb /Hct _____(201)

Name of HCP verifying applicant lives in Alaska _____ **ID Verified by**: Visual Recognition___/Other _____WIC

Name of CPA reviewing WIC application_____ Certification Date _____

Parents often wonder if their child is eating right.

16. On a scale of 0 to 10, how well do think your child is eating? (Circle a number)

Not Well 0 1 2 3 4 5 6 7 8 9 10 Very Well

He/she usually eats ___meals /day and __snacks/day.
He/she usually eats fruits/vegetables (check amount)

- ☐ 1 cup/day or less of fruits/vegetables
- ☐ 2 cups/day or less of fruits/vegetables
- ☐ 3 cups/day or more of fruits/vegetables

17. My child eats: **425.04, 428**

☐ Liquid Foods ☐ Finger Foods
☐ Table Foods ☐ Mashed, Pureed/ Baby Foods

18. Does your child eat meals with the family?
Comment: _____
_____

19. Is your child is on a special diet? ☐ No ☐ Yes **425.06**
Describe _____
_____

20. My child drinks from:(check all that apply) **425.03**

☐ Sippy Cup ☐ Cup ☐ Bottle

If your child drinks from a bottle, please tell us:

- Number of bottles in 24 hours? _____
- What is in the bottle? _____

21. When does your child get a bottle? **425.03**

☐ Bedtime/Naptime ☐ Mealtime
☐ All day ☐ Other _____

22. When do you want your child to only use a cup?
_____

23. **Check the box if you have any of the following concerns about your child**: **342**

☐ Constipation ☐ Diarrhea
☐ Vomiting ☐ Chewing/Swallowing
☐ Choking/Gagging ☐ Other_____

24. Does your child crave or eats non-food things like dirt, clay, soap, ice, cigarette butts, ashes, carpet fibers, paper, dust, foam, rubber, paint chips, soil, starch (laundry or cornstarch) or other?

☐ No ☐ Yes **425.09**

25. I am breastfeeding my child. ☐ No ☐ Yes

26. If your child used(s) formula, at what age did you first offer formula? ___ weeks or __months old

27. List any medication, vitamin, mineral or herbal supplement your child takes. **357, 425.07, 425.08,**
_____
_____
_____

28. **Check the box and circle the foods your child eats.**

- ☐ Raw or undercooked meat, poultry, fish, eggs
- ☐ Foods with raw or undercooked eggs, like salad dressings, cookie and cake batters, sauces
- ☐ Unheated hot dogs, luncheon meats, fermented and dry sausage, deli-style meat or poultry
- ☐ Refrigerated Smoked Seafood (unless it is cooked)
- ☐ Soft cheeses made with un-pasteurized milk: Feta, Mexican style (queso blanco fresco), Brie, Blue
- ☐ Raw sprouts (alfalfa, clover and radish)
- ☐ Un-pasteurized milk, fruit or vegetable juice or foods made with Un-pasteurized milk **425.05**

29. **Check if your child drinks regularly** **425.01, 425.02**

☐ Water ☐ Skim Milk ☐ Dry Milk
☐ Pedialyte ☐ Breast milk ☐ Raw milk
☐ Soy milk ☐ Sweet tea ☐ Formula
☐ Raw juice ☐ Rice milk ☐ Pop/Soda
☐ Whole Milk ☐ 100% Pasteurized Juice
☐ Fruit drink *(not 100% juice)* ☐ Sport Drinks
☐ 2% or 1% Milk ☐ Evaporated Milk
☐ Tang/Kool-Aid ☐ Cereal/Solids foods in bottle
☐ Coffee/tea ☐ Other_____

30. In a typical day, how much time does your child watch TV, play video and/or play computer games?

☐ Less than 1 hour ☐ 1-2 hours
☐ More than 2 hours

31. What does your family do for fun?
_____
_____

32. **How can WIC help your family today**?
_____
_____
_____
_____

Thank You!